MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95-C

06332

Reg. Dist. No. 260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Somerset
City or town: Mt. Vernon (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, Institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: New York County: Richmond
City or town: West New Brighton (If outside city or town limits, write RURAL and give nearest town)
Street No. 64 Reed Boulevard (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Hugo N. Anderson

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mafflid Jenny Anderson
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Dec. 5, 1883.

8. AGE:

Years	Months	Days	If less than one day
61	6	19	..... hrs. ..... min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Coal Dealer
11. Industry or business: ✓

FATHER
12. Name: Not Known
13. Birthplace: " "

MOTHER
14. Maiden name: Not Known
15. Birthplace: " "

16. Informant: Walter F. Anderson
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)
Cemetery or crematory: Parsons Memorial Park
Location: Salisbury, Md.
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. June 25 45 (Date rec'd by registrar) R. L. Johnson M.D. Registrar

Paid.

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24, 1945, at 7.30 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Acute Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (Which?) ..... County .....
Means of injury ..... Injured at work?

HENRY M. LANKFORD, M.D.
Deputy Medical Examiner
for Somerset County

23. SIGNATURE: Henry M. Lankford M.D. M. D. or other
Address: Princess Anne, Md. Date signed 6/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

06333

06333

Reg. Dist. No. 260

1. PLACE OF DEATH:
County Somerset
City or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset Co
City or town Princess Anne, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wm. Thomas Bozman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 16 1870

8. AGE: Years	Months	Days	If less than one day
74	11		..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Asie Bozman
13. Birthplace Md

MOTHER 14. Maiden name Mary Lawrence
15. Birthplace Md

16. Informant Lehan Bozman
Address Princess Anne

17. Oriole (Burial, cremation, or removal. Which?) Date thereof June 8 1945 (month) (day) (year)

Cemetery or crematory Jr. Order
Location Oriole

18. Funeral director P. J. Smith
Address Princess Anne

19 June 7 1945 (Date rec'd by registrar) Lt Coleman MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6th 19 45 at 1 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death — DURATION

Cerebral Hemorrhage — few hours

Due to.....

Due to.....

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE P. J. Smith M. D. or other
Address Pr Anne Md Date signed 6/7-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of birth date of deceased is shown on FILM No. G 95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06334

Reg. Diat. No. 27 D

1. PLACE OF DEATH:
County: Somerset
City or town: Crisfield Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 wk
Hospital, institution, or street address where death occurred:
Edward W. McCready Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Marion
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William James Connor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida May Connor
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Dec 17 ~~1875~~ 1873

8. AGE: Years	Months	Days	If less than one day
71	5	16	hrs. min.

9. Birthplace: Marion Somerset Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Nathan Connor
13. Birthplace: Marion Md

MOTHER
14. Maiden name: Eliza Jane Whittington
15. Birthplace: Marion Md

16. Informant: Mrs W J Connor
Address: Marion Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1945 (month) (day) (year)
Cemetery or crematory: St Pauls cemetery
Location: Marion Md

18. Funeral director: John A Bradshaw
Address: Crisfield Md

19. 6/5 (Date rec'd by registrar) 19 45 Eurelia P. Lawson Registrar
C. E. Collins M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sun. June 3, 19 45, at 5 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 19 45 to June 3 19 45
and that I last saw h.. alive on June 3, 19 45

Immediate cause of death	DURATION
Acute dilation of heart	
Due to: Peritonitis and appendicitis	
Due to:	
Other conditions: Chronic Myocarditis + Chronic Dif. Nephritis (Include pregnancy within 3 months of death)	

Major findings of operations: peritonitis gangrenous appendicit Date of op. May 31, 1945
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death wss due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured st home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George L. Shellman M.D. M. D. or other
Address: Marion Md Date signed June 4 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

06335

Reg. Dist. No. 246

1. PLACE OF DEATH:

County: Everett Somerset

City or town: Ewell
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 80 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Ewell Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Margaret Ann Corbin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Lawrence A. Corbin

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 13 1864

8. AGE: Years	Months	Days	If less than one day
80	8	28	hrs. min.

9. Birthplace: Smith Island, Somerset, Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Jessie Evans
13. Birthplace: Smith Island Md

MOTHER
14. Maiden name: Levina Bradshaw
15. Birthplace: Smith Island Md

16. Informant: J A Bradshaw
Address: Crisfield Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13 1945 (month) (day) (year)

Cemetery or crematory: Ewell cemetery

Location: Smith Island Md

18. Funeral director: John A Bradshaw

Address: Crisfield Md

19. June 13 1945 (Date rec'd by registrar) Carrie Ritching Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 10 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 1945 to May 12 1945, and that I last saw her alive on June 10 1945.

Immediate cause of death	Chronic Heart disease	DURATION
Due to	Chronic nephritis, Cystica-Gelosis	
Due to	Senility	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W Krabold
M. D. or other

Address: Ewell, Maryland Date signed 6-11-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUN 15 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1

M

T

06336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 261

1. PLACE OF DEATH:

County: Somerset

City or town: Westover, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Westover, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Catherine Josephine Darnall

3.(b) Social Security Number: ✓

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Charles N. Darnall

6.(c) If alive, give age: .... years

7. Birth date of deceased (mo., day, yr.): January 10, 1870

8. AGE: Years: 75 Months: 5 Days: 18 If less than one day: .... hrs. .... min.

9. Birthplace: Brooklyn N.Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Narssis Bouchard
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret Dardy
15. Birthplace: Missouri

16. Informant: Mrs. Francis Cluff
Address: Westover, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 2, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D.C.

18. Funeral director: Marguritte H. Watson

Address: Pocomoke City, Md.

19. 6/30 1945 (Date rec'd by registrar) Amelia B. Lawson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to June 28 1945 and that I last saw her alive on June 27 1945

Immediate cause of death	DURATION
Coronary occlusion. Acute Dis. of Heart.	3 days
Due to: Chronic Int. nephritis. Chronic myocarditis	2 years
Due to: General arterio sclerosis	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .... Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work? ....

23. SIGNATURE: George C. [illegible] M.D. or other

Address: Marion Sta. Md. Date signed: June 29 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-d)

CERTIFICATE OF DEATH

06337

Reg. Diat. No. 7-65

1. PLACE OF DEATH:

County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Harriet Virginia Evans

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June ? 1880

8. AGE: Years	Months	Days	If less than one day
65	?	?	..... hrs. ..... min.

9. Birthplace: Dames Quarter, Somerset, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: "

MOTHER

14. Maiden name: "

15. Birthplace: "

16. Informant: William Evans

Address: Crisfield Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 1945 (month) (day) (year)

Cemetery or crematory: Sunnyridge Park cemetery

Location: Crisfield Md

18. Funeral director: John A Bradshaw

Address: Crisfield Md

19. June 2 1945 (Date rec'd by registrar) C E Kelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to June 1 1945

and that I last saw h[illegible] alive on June 1 1945

Immediate cause of death	DURATION
Pneumonia	
Due to: Flu	
Influenza	8 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C E Kelly M. D. or other

Address ..... Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

★06338

Reg. Dist. No. 261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Somerset

City or town: Rehoboth, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-4 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Somerset

City or town: Rehoboth Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Heath

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widower

6.(b) Name of husband or wife: Louease Heath

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18 - 1889

8. AGE:

Years	Months	Days	If less than one day
56	2	16	hrs. min.

9. Birthplace: Marion Somerset Co Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: George Heath

FATHER — 13. Birthplace: Somerset Co Md

MOTHER — 14. Maiden name: Louise Parsfield

MOTHER — 15. Birthplace: Somerset Co Md

16. Informant: Louise Dixon

Address: 1934 Harlem st Phila Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10 1945 (month) (day) (year)

Cemetery or crematory: Greenlawn

Location: Marion Md

18. Funeral director: Chas H Ward

Address: Marion Sta, Md

19. 6/9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 45 1945, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945, to June 4 1945

and that I last saw him alive on May 24 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	1 hr
Due to: Chronic Int. Nephritis	4 yrs
Due to: Senile Myocarditis	
Other conditions: Arterio Sclerosis & Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Corkum M. D. or other

Address: Marion Sta Md Date signed: June 9 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06339

Reg. Dist. No. 261

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Somerset
City or town: Westover, Maryland RD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - about 47 years -
Hospital, institution, or street address where death occurred:
at Home - Westover, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Somerset
City or town: Westover
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henrietta Hunter

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Last Husband - Bill Hunter
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 1st 1874

8. AGE: Years: 71yrs | Months: | Days: 24dys | If less than one day: hrs. min.

9. Birthplace: Oxford, Talbot Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Do not know
13. Birthplace: Do not know
MOTHER 14. Maiden name: Do not know
15. Birthplace: Do not know
16. Informant: Christopher Robinson
Address: Westover, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27 1945 (month) (day) (year)
Cemetery or crematory: Waters Chapel
Location: Kingston, Md.
18. Funeral director: Geo. W. Dilgliman
Address: Marion, Md.
19. 6/26 1945 (Date rec'd by registrar) Lucia B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25 1945 at 12 40 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to June 25 1945 and that I last saw her alive on June 15 1945

	DURATION
Immediate cause of death: Acute Duodenal Ulcer	1 hr
Due to: Ulcers Duodenal regular	6 mths
Ulcers Myocardial	
Due to:	
Other conditions: General Arteriosclerosis	Yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Coulbourn M.D.
M. D. or other
Address: Marion Md. Date signed: June 26 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 06344

Reg. Dist. No. 260

1. PLACE OF DEATH

County Somerset

City or town Union Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Westover, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Jasper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	B	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1877

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace Mt Vernon (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Bowers

13. Birthplace Mt Vernon Md.

MOTHER 14. Maiden name Rachel Hall

15. Birthplace Mt Vernon, Md.

16. Informant Nellie Smith

Address Union, Md.

17. (Burial, cremation, or removal, which?) Burial Date thereof June 17, 1945 (month) (day) (year)

Cemetery or crematory St Paul Cemetery

Location Mt Vernon Md.

18. Funeral director Wade Dashiell

Address Princess Anne Md.

19. June 16 1945 (Date rec'd by registrar) R. H. Johnson M.D. Registrar Perd.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17th 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death Arteriosclerosis	DURATION
Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. Smith M. D. or other

Address Date signed 6/17 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

★ 06341

Reg. Dist. No. 361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Somerset

City or town: Marion

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Marion

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colard	married

6.(b) Name of husband or wife: Garfield Jones

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct 8 1879

8. AGE: Years	Months	Days	If less than one day
65	9	10	..... hrs. ..... min.

9. Birthplace: Marion Somerset Co Md

(Town, county, and state)

10. Usual occupation: Home Worker

11. Industry or business

FATHER

12. Name: Joseph Green

13. Birthplace: Marion Somerset Co Md

MOTHER

14. Maiden name: Annie Outten

15. Birthplace: Marion Somerset Co Md

16. Informant: Garfield Jones

Address: Marion Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21 1945 (month) (day) (year)

Cemetery or crematory: Spanish Cemetary

Location: Marion Md.

18. Funeral director: Chas H Ward

Address: Marion Md.

19. 6/20 1945 (Date rec'd by registrar) Turelia B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 1945, at 11 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 18 1945 and that I last saw her alive on June 17 1945

Immediate cause of death	DURATION
Acute Dilat of Heart	
Due to: Nephritis	
Due to: Chronic Interstitial	4 years
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Guillum M D

M. D. or other

Address: Marion Md Date signed June 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

06342

★ Reg. Dist. No. 760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Somerset
City or town: Oriole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somerset
City or town: Oriole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Olivia Waters Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Col.	Widow

6.(b) Name of husband or wife: Harry Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1886

8. AGE: Years	Months	Days	If less than one day
68	8	3	hrs. min.

9. Birthplace: Pocomoke, Md. Worcester
(Town, county, and state)
10. Usual occupation: house maid
11. Industry or business

FATHER
12. Name: Vincent Waters
13. Birthplace: Pocomoke Md. Worcester

MOTHER
14. Maiden name: Annie E. Murray
15. Birthplace: Caroline Co.

16. Informant: Florence S. Waters
Address: Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27, 1945 (month) (day) (year)
Cemetery or crematory: Oriole
Location: Oriole Md.
18. Funeral director: Chas. H. Ward
Address: Marion Md.
19. June 26, 1945 (Date rec'd by registrar) L. D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25th 1945, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945, to June 25th 1945
and that I last saw her alive on June 25th 1945.

Immediate cause of death	DURATION
Chronic Myocarditis	2 years
Due to	
Due to	
Other conditions: Diabetes Mellitus	8 years

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Eleanor G. Mewshaw M. D. or other
Address: Princess Anne Md. Date signed: 6-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

★6343 Reg. Dist. No. 270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Somerset
City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ~~Xxxx~~ Life
Hospital, institution, or street address where death occurred:
McCready Memorial
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. •
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 2

3.(a) FULL NAME: Whelton L. McCready

3.(b) Social Security Number: 218-01-2499

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1912

8. AGE: Years	Months	Days	If less than one day
32	9	23	..... hrs. ..... min.

9. Birthplace: Crisfield, Md.
(Town, county, and state)

10. Usual occupation: Truck Drive

11. Industry or business: Saltz Furniture Co.

FATHER
12. Name: Frances A. McCready
13. Birthplace: Crisfield, Md.

MOTHER
14. Maiden name: Nancy B. Whealton
15. Birthplace: Crisfield, Md.

16. Informant: Nancy B. McCready
Address: RFD Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)
Cemetery or crematory: American Legion
Location: Crisfield, Md.

18. Funeral director: Howard H. Hubbard
Address: 306 Main St., Crisfield, Md

19. 6/27/45 19.. C. E. Collins M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 25, 1945 19.. at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
Fractured Skull	
Due to: Crushed Chest	
Due to: Shock Due to	
Due to: Automobile	
Other conditions: Accident	

(Include pregnancy within 3 months of death)

William H. Coulbourn, M. D.
DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY, MD.

Major findings of operations: ..... Date of operation: .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident on 6/24/45

Accident, suicide, or homicide: ..... Date of injury: .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) ..... How injury occurred: Auto accident

Injured at work? No

23. SIGNATURE: William H. Coulbourn M.D. M. D. or other

Address: Crisfield Md Date signed: 6/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06344

Reg. Diat. No. 265

1. PLACE OF DEATH:

County: Somerset

City or town: RURAL, Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 948 W. Broad Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Perry Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4, 1942

8. AGE:

Years	Months	Days	If less than one day
3	2	20	hrs. min.

8. Birthplace: Elizabeth City, North Carolina (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John Perry
13. Birthplace: Crisfield, Maeyland

MOTHER
14. Maiden name: Lucile Atkins
15. Birthplace: White Stone, Virginia

16. Informant: Lucile Atkins

Address: Broad St., Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6 (month) 27 (day) 1945 (year)

Cemetery or crematory: Hopwell Cemetery

Location: RURAL, Crisfield, Md.

18. Funeral director: H. Harvey Bradshaw

Address: Crisfield, Maryland

19. 6/27/45 (Date rec'd by registrar) 19 C E Collins M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945 at 530 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Was Dead when I arrived 19 to 19 and that I last saw him alive on 19

	DURATION
Immediate cause of death: Fell off boards hit head on Edge of Brick	
Due to: Fractured Skull	
Due to: Shock	
Other conditions:	

(Include pregnancy within 3 months of death)

William H. Coulbourn, M. D.
DEPUTY MEDICAL EXAMINER
FOR SOMERSET COUNTY, MD.

Major findings of operations: Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide: Date of June 24-45

Where did injury occur? Crisfield Somerset Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Fell off boards Injured at work?

23. SIGNATURE: Wm H Coulbourn M. D. & other

Address: Crisfield Md. Date signed: June 27 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (N)

CERTIFICATE OF DEATH

06345

Reg. Dist. No. 260

1. PLACE OF DEATH:

County Somerset

City or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sidney Fairfax Revell

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10th 1855

8. AGE:

Years	Months	Days	If less than one day
89	10		hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation merchant

11. Industry or business

FATHER 12. Name John Revell

13. Birthplace Md

MOTHER 14. Maiden name Mary Collett

15. Birthplace Md

16. Informant Mrs. Florence Collins

Address P. Anne

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1945 (month) (day) (year)

Cemetery or crematory Manokin

Location near Princess Anne

18. Funeral director P M Smith

Address Princess Anne

19. June 11 1945 (Date rec'd by registrar) R. T. Johnson M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 10th 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive 19

	DURATION
Immediate cause of death Pneumonia	
2 feet	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Smith M. D. or other

Address Princess Anne Md Date signed 6/11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 06346

Reg. Diat. No. 261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Somerset

City or town: Marion

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Somerset

City or town: Marion

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sallie Roberts

3.(b) Social Security Number 212-16-7297

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	colored	widower

6.(b) Name of husband or wife: Samuel Roberts

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): mar 24 - 1873

8. AGE:

Years	Months	Days	If less than one day
72	2	22	..... hrs. ..... min.

9. Birthplace: Westover Somerset Co Md (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER

12. Name: Frank White

13. Birthplace: Westover Somerset Co Md

MOTHER

14. Maiden name: Louisa Hayward

15. Birthplace: Westover Somerset Co Md

16. Informant: Clarance Spence

Address: Marion Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 1945 (month) (day) (year)

Cemetery or crematory: Bethany

Location: Westover, Md

18. Funeral director: Chas H Ward

Address: Marion Md

19. 6/19 1945 (Date rec'd by registrar) Eurelia B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1945, at 11 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to Jun 16 1945

and that I last saw h.. alive on Jun 15 1945

Immediate cause of death	DURATION
Cerebral Thrombosis	10 days
Due to Arteriosclerosis	12 yrs
Due to Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo C Cullum MD M. D. or other

Address: Marion Md Date signed June 18, 45

Evidence for change of age is shown on FILM No. G 95 JUN 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T

06347

Reg. Dist. No. 260

1. PLACE OF DEATH:
County Somerset
City or town East Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Somerset Co.
City or town East Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lillie Virginia Ross

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1864

8. AGE: Years 80 | Months | Days | If less than one day hrs. min.

9. Birthplace Princess Anne, Somerset Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business House Work

FATHER 12. Name La. G. Ross

13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden name Matilda Dryden

15. Birthplace Somerset Co. Md.

16. Informant Millard Ross

Address Princess Anne Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14, 1945 (month) (day) (year)

Cemetery or crematory Presbyterian Cem.

Location Princess Anne, Md.

18. Funeral director Dale Mashall

Address Princess Anne Md.

19. June 12 1945 (Date rec'd by registrar) R. D. Johnson Md. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to	
Due to	
Other conditions Don't know	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Kinsch M. D.
M. D. or other
Address R. B. Kinsch M.D. Date signed 6/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-a)

CERTIFICATE OF DEATH

06348

Reg. Dist. No. 261

1. PLACE OF DEATH:
County: Somerset
City or town: Marion
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Marion
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Edna Tyler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward P Tyler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 21 1870

8. AGE: Years	Months	Days	If less than one day
75	0	25	..... hrs. ..... min.

9. Birthplace: Crisfield Somerset Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Bloxom
13. Birthplace: ? Va.

MOTHER
14. Maiden name: Nancy Lawson
15. Birthplace: Crisfield Md

16. Informant: Mrs Grover Somers
Address: Marion Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 18 1945 (month) (day) (year)
Cemetery or crematory: Sunnyridge cemetery
Location: Crisfield Md

18. Funeral director: H Harvey Bradshaw
Address: Crisfield Md

19. 6/18 1945 (Date rec'd by registrar) Eurelia B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16 1945, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to June 16 1945 and that I last saw h.. alive on June 16 1945

	DURATION
Immediate cause of death: Acute Dil of Heart	4 days
Due to: Uremia & Chronic Int nephritis	
Due to: Chronic myocarditis	10 years
Due to: General Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Geo E Coulbourn M D
M. D. or other
Address: Marion Md Date signed June 18 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH:
County: Somerset
City or town: Chance
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 78
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Somerset
City or town: Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Isaac Waller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Waller
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Sept 25 ~~1867~~ 1866

8. AGE: Years	Months	Days	If less than one day
78	8	24	...hrs. ...min.

9. Birthplace: Chance Somerset Maryland
(Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business

FATHER
12. Name: Isaac Waller
13. Birthplace: Salisbury Md

MOTHER
14. Maiden name: Susan Arnold
15. Birthplace: ? Va

16. Informant: Mrs Emma Waller
Address: Chance Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 22 1945 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemtery
Location: Chance Md

18. Funeral director: H Harvey Bradshaw
Address: Crisfield Md

19. June 21 1945 (Date rec'd by registrar) L. H. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 19th 1945, at 11:15 A.M. ~~11:15 A M~~

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1941, to June 19 1945; and that I last saw him alive on June 19 1945

Immediate cause of death	DURATION
arteriosclerotic Heart Disease	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Waters M.D. M. D. or other
Address: Dr. Princess Anne Date signed June 20

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46-E

46350

Reg. Dist. No. 2-60

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Somerset
City or town Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Princess Anne Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Erma L. White

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife William White
6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1914

8. AGE: Years	Months	Days	If less than one day
31	4	8	hrs. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Schaeffer
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden name Celia Cunningham
15. Birthplace Philadelphia Pa.

16. Informant William White
Address Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16, 1945 (month) (day) (year)
Cemetery or crematory Hillside Cemetery Philadelphia Pa
Location Princess Anne Md

18. Funeral director Dale Dashiell
Address Princess Anne Md.

19. June 15 1945 R. L. Johnson M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1945 19 45 at 9 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 19 45 to June 14 19 45
and that I last saw her alive on June 14 19 45

Immediate cause of death Carcinoma of transverse Colon, Pelvic Fracture Due to with metastasis to liver — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Operation 18 Mo. ago in Philadelphia. Diagnosis Confirmed.

Autopsy results Not Made

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Johnson M.D.
M. D. or other
Address Princess Anne, Md Date signed June 18-45